

**American Equity Policy Service Form**  
**North Carolina National Guard Association**  
**7410 Chapel Hill Road Raleigh, NC 27607-5047**  
**919-851-3390 info@ncnga.org**

**BENEFICIARY DESIGNATION**

I (we) ask the beneficiary of the above policy be changed as shown below. All prior beneficiary designations are revoked. I (we) agree that the Company is free from liability in relying on a statement about birth, death, marriage, names, addresses and other facts concerning all beneficiaries from any other one. Unless otherwise stated, the survivors of a beneficiary class share equal amounts of the proceeds.

**I would like to change my Beneficiary on my Group Life Policy to:**

<input checked="" type="checkbox"/> List beneficiary's full name and address _____ _____	<input checked="" type="checkbox"/> Relationship To insured _____ _____	<input checked="" type="checkbox"/> Date of Birth ____/____/____ ____/____/____	<input checked="" type="checkbox"/> % of Proceeds _____ _____
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<input checked="" type="checkbox"/> List beneficiary's full name and address _____ _____	<input checked="" type="checkbox"/> Relationship To insured _____ _____	<input checked="" type="checkbox"/> Date of Birth ____/____/____ ____/____/____	<input checked="" type="checkbox"/> % of Proceeds _____ _____
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If none of the above are living or this designation is ineffective proceeds will be paid to the insured's estate. If you name a Trust as the Beneficiary, submit a copy of the trust for our file.

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 Unless the Company has been notified of a community property interest in this policy, the Company shall be entitled to rely on its good faith belief that no such interest exists and assumes no responsibility for inquiry. The insured and/or policy owner signing this form agrees to indemnify and hold the Company harmless from the consequences of accepting this transaction.  
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**1. NAME CHANGE: Insured Only**

Former Name \_\_\_\_\_ New Name \_\_\_\_\_  
 Date Named Changed \_\_\_\_/\_\_\_\_/\_\_\_\_ Reason \_\_\_\_\_

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**2. ADDRESS CHANGE: Owner Insured**

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 EMAIL ADDRESS: \_\_\_\_\_

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**3. LOST POLICY REQUEST:**

\_\_\_\_\_ I am unable to find the policy named above. I request that the company issue a Certificate, which validates all of the provisions of the last Policy.

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 \_\_\_\_\_  
 Signature of Witness (someone other than beneficiary)       \_\_\_\_\_  
 Member's Name:  \_\_\_\_\_      Member's SSN:  \_\_\_\_\_  
 (Please Print)      Date

\*\*\*\*\*  
 The Company has recorded the change requested and retained a photocopy of the request. Date \_\_\_\_/\_\_\_\_/\_\_\_\_ By \_\_\_\_\_

If you have questions, please call 919-851-3390 ext 0